3.526(c) Systematic Reduction of Debt
Allowable interest expense may not exceed the amount which would have been incurred under a systematic reduction of debt. The calculation of this limitation varies based on whether a facility makes at least annual principal payments or deposits to a segregated interest-bearing account.

If a facility makes at least annual principal payments or deposits to a segregated, interest-bearing account which will result in repayment of the debt at maturity, a systematic reduction of debt means a debt which has:

1. Payments of interest and principal which are uniform over the total length of debt; and
2. A length not exceeding the lesser of forty (40) years or the remaining useful life of the longest lived asset acquired with debt proceeds.

Allowable interest expense is predicated upon required systematic reduction of debt.

If a facility does not make at least annual principal payments or deposits, a systematic reduction of debt will be determined by the Department through:

1. An amortization schedule for a period of thirty (30) years from the date of asset acquisition;
2. Applying the interest rate as stated in the debt contract;
3. For debt contracts entered into prior to July 1, 1990, assuming a principal reduction schedule beginning July 1, 1990, and ending thirty (30) years from the original loan date; and
4. Reducing the calculated interest expense by any investment income on segregated funds.

3.526(d) Interest Expense Related to Refinancing of Debt
The recognizable debt balance following refinancing will be determined as:

Long Term Debt
1. The remaining balance of the original debt as determined under Sections 3.526(b) and 3.526(c); plus
2. The cost of assets acquired in the year of refinancing and then adjusted the following two fiscal years for additional assets acquired; plus

Separate short term Working Capital
1. The financing fees related to the refinancing

The allowable interest expense for refinancing arrangements may not exceed the amount which would have been allowed on the recognizable debt balance, excluding financing fees, had the refinancing not occurred.

Systematic reduction of debt under Section 3.526 is required for refinancing arrangements.

3.526(e) Reduction for Investment Income
The allowable interest expense after applying Sections 1.270 and 3.526(a)1 through 4 will be reduced by the amount of any investment income of the facility or related entities, including foundations, home offices, etc. per Section 1.270, to the extent that total property related expenses exceed the Target (T1) described in Section 3.532. Investment income offset will not include income from donor-restricted funds provided that there is separate accounting for such funds, that the funds are used for their intended purpose, and there is no future benefit to the donor, grantor, or endower. Reserves needed by Continuing Care Retirement Centers to offset lifetime contracts can be calculated by their actuaries if lifetime contracts do not require residents to apply for Medicaid if the resident's fund are exhausted.

3.527 Property Insurance
Allowable property insurance expense will be the accrual-based expense from the base cost reporting period. This expense will be subject to allocations for revenue-producing areas and for non-nursing home areas. Allowable property insurance expense includes mortgage insurance required by the lender.

3.528 Inadequate Documentation
Where the provider, or in the case of changes of ownership, the buyer or seller of a nursing home, is unable or unwilling to provide adequate documentation of acquisition cost, acquisition date or other data relevant to the property-related expenses, or if the provider does not comply with property documentation requests by the Department or the contractor under Section 3.531, the Department will determine the values, dates and data through use of secondary sources of information, such as income and property tax records, and may use the source which results in the lowest value or the lowest property payment allowance.

3.530 Calculation of Property Allowance

3.531 Equalized Value

The equalized value will be derived from the values determined by an independent contractor under contract with the Department, using the E. H. Boeckh Commercial Valuation System. Any values established by such contract will be indexed, if necessary, to the current rate year. The equalized value will be the Depreciated Replacement Cost (DRC) from the E. H. Boeckh valuation after adjustment under Sections 3.531(a) and (b). These values will not be modified by any sales price; by a market appraisal by a certified appraiser on behalf of the facility; or by the assessed value on the property tax rolls.

The total value of the facility will be the sum of the values determined for the separate sections of the facility.

A facility's equalized value shall be based upon the values determined above, including adjustments, unless the facility does not render payment under Section 4.697 within a reasonable time period. In such instance, the facility's property allowance will be reduced by applying fifty percent of the facility's June 30, 2002, DRC and Undepreciated Replacement Cost (URC) under Section 3.531(b) or by fifty percent of the facility's June 30, 2002, property allowance, whichever is lower. This reduction applies to both the interim rate granted, if any, and the final rate. Upon facility payment of the appraisal cost, this reduction will be restored on a retroactive basis to the effective date of the reduction, and the facility property allowance will be calculated as determined by the provisions of the Methods.

3.531(a) Allocation for Areas Not Related to Routine Services

The values derived from the Boeckh valuation will be adjusted to exclude the value of areas not related to routine services. To the extent possible, this adjustment will be based on the square footage used in the Boeckh valuation.

3.531(b) Maximum on Equalized Value

The Undepreciated Replacement Cost (URC) arrived at under the Boeckh valuation system shall not exceed the equalized value in Section 5.830 times the beds for rate setting (Section 3.040) for allowances calculated under this Methods. Where this maximum is exceeded, the equalized value will be adjusted proportionately. This calculation can be expressed as follows:

For: Boeckh URC = The Boeckh Undepreciated Replacement Cost after Section 3.531(a) square footage adjustments;

Boeckh DRC = The Boeckh Depreciated Replacement Cost after Section 3.531(a) square footage adjustments

URC = Allowable Undepreciated Replacement Cost (the lesser of Boeckh URC or the equalized value in Section 5.830)

Then allowable Equalized Value (EV) is calculated as:

EV = (Boeckh DRC/Boeckh URC) X URC

3.532 Property Allowance Calculation

A target amount (T1) will be calculated for each facility by multiplying the equalized value from Section 3.531 by a service factor described in Section 5.820 (a).

When a facility's allowable property-related expenses are less than the target amount (T1), the property payment allowance will be allowable expense plus the incentive value in Section 5.850 times the amount by which expense is less than the target (T1). When the facility's allowable property-related expenses are equal to or greater than the target amount, the property payment allowance will be the target amount plus 100% of the amount by which allowable expense exceeds the target up to the factor in Section 5.820 (b), and the cost share value in Section 5.840 times the amount by which allowable expenses under Section 3.521 exceed the factor in Section 5.820 (b).

This calculation can be expressed:

For:
E = Allowable property-related expenses up to Section 3.521 maximum;
T1 = The service factor in Section 5.820 (a);
T2 = The service factor in Section 5.820 (b);
PA = Total property payment allowance;
I = Increment described in Section 5.810;
C = Cost Share Value described in Section 5.840; and
N = Incentive described in Section 5.850.

Then: Where E is less than T1:

$$PA = (E + N * (T1 - E)) + I$$

Where E is equal to or greater than T1 and E is less than T2:

$$PA = E + I$$

Where E is greater than T2:

$$PA = (T2 + C * (E-T2)) + I$$

Facilities which have completed a Ch. 150 Resource Allocation Program approved project involving construction or renovation of physical plant between July 1, 1996, and December 31, 1997, will have a cost share percentage as described in Section 5.840(b). Nursing facilities that have a licensed bed capacity of 50 beds or less, after adjustments in Section 3.000, will have a cost share as described in Section 5.840(b). Facilities that are certified as ICF/MR, either in whole or in part, will have a cost share as described in Section 5.840(a), unless they have completed a RAP-approved project as noted above.

3.534 Per Patient Day Property Payment Allowance
To calculate the per patient day property payment allowance, the property allowance (Section 3.532) is divided by the adjusted patient days in Section 1.307 times the minimum occupancy factor in Section 3.030. If needed, the expenses shall be adjusted to the length of time covered by the patient days.

For calculating the per patient day property payment allowance for newly-licensed facilities and facilities with significant licensed bed increases, the patient day provisions of Sections 4.320 and 4.420 will apply. For replacement facilities, the minimum occupancy standard in Section 3.030 will be applied.

3.537 Maximum Decrease
A facility's payable property allowance will not be reduced by more than $3.50 per patient day from the allowance in effect on June 30, 2002. An exception to this maximum decrease is made if the June 30, 2002, allowance is subject to adjustment after June 30, 2002, for the lapsing of the "start-up" occupancy provisions for newly-licensed or expanded facilities. In these cases, the $3.50 maximum reduction is measured from the allowance which would have resulted from applying the Methods in effect on June 30, 2002.

3.600 OVER-THE-COUNTER DRUGS ALLOWANCE
Reimbursement for certain over-the-counter (OTC) drugs ordered by a physician and provided to Wisconsin Medicaid residents shall be made as part of the facility's daily rate. The OTC allowance will be based on the facility's cost of OTC services for Wisconsin Medicaid residents from the base cost reporting period, as limited by the provisions under Section 2.600.

Payment for OTC drugs will be determined using the following formula:

For: P = OTC allowance;
E = Facility's allowable expense for Wisconsin Medicaid resident OTC drugs as adjusted to the common period by an inflation/deflation factor (Inflation factors are listed in Section 5.330); divided by adjusted Medicaid patient days

Emin = Expense at minimum occupancy,

E * Minimum Occupancy Factor in 3.030

CMI-T19 = From Section 3.122

T = Target for OTC expense in section 5.910 * CMI-T19
I = Inflation rate to payment period by inflation factor listed in Section 5.910; and

If Emin is less than T

$$P = (Emin* \times I) + 0.50 (T-Emin)$$

If Emin is greater than T

$$P = (TxI) + .50 (Emin-T)$$

3.650 PROVIDER INCENTIVES

3.651 Exceptional Medicaid/Medicare Utilization Incentive

MM% = The facility's adjusted Medicaid patient days plus Medicare patient days divided by the facility's adjusted total patient days under Section 1.307. The MM% must be greater than or equal to 70.0% in order to receive the EMMUI. Payment for the EMMUI supplement will be determined per the table in Section 5.920. The incentive will vary based on the MM% and the beds for rate setting of the facility.

3.652 Energy-Savings Incentive

If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility will receive an incentive equal to the lessor of 25% of the projected cost of the project, as approved by the Department, or 25% of the actual cost of the project per year for two years. The incentive payment will be effective July 1 following completion of the project. Allowable costs for the project will be subject to minimum occupancy factor under Section 3.030.

3.653 Private Room Incentive

a. Basic Private Room Incentive (BPRI)
A basic private room incentive will be determined using the following formula:

BPRI = PRP x BBA

where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 15% **AND** the facility's adjusted Medicaid patient days plus Medicare patient days divided by the facility's adjusted total patient days under Section 1.307 must be greater than or equal to 70% in order to receive the BPRI

and BBA = The basic base allowance in Section 5.930

b. Renovation Private Room Incentive (RPRI) and Replacement Private Room Incentive (RPPRI)
A renovation private room incentive or replacement private room incentive will be determined using the following formula:

RPRI or RPPRI = PRP x RBA

where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 90% **AND** the MM% from Section 3.651 must be greater than or equal to 70.0% in order to receive the RPRI or RPPRI.

and RBA = The renovation base allowance in Section 5.930

A facility may receive only one incentive.

3.700 FINAL RATE DETERMINATION

3.710 General

Sections 3.710 through 3.770 describe the process for determining a facility's final payment rate by level of care for direct care services, support services administrative and general, fuel and other utility expense, over-the-counter drug expenses and property taxes. This process shall be followed whenever any payment allowance under Sections 3.100, 3.200, 3.250, 3.300, 3.400 or 3.600 is adjusted or recalculated. Any average amount under this section shall be the average as weighted by the adjusted patient days by level of care which were used in calculating the direct care allowance under Section 3.100. The Department shall specify the patient day period.

3.720 Base Rate

3.721 Base Rate Described

A facility's base rates shall be the total rates effective for each level of care for services rendered on June 30, 1994, excluding the capital allowance, ancillary add-ons, special allowances for local government-operated facilities and rate adjustments made by the Nursing Home Appeals Board, but including reimbursement for over-the-counter drugs under Section 3.600. An average base rate shall be calculated under Section 3.710 for each facility.

3.722 Base Rate Modification

The base rates shall be modified according to the following:

1. Adjustments. Base rates shall include any audit adjustments or corrections subsequent to June 30, 1994, that are deemed effective for date-of-service June 30, 1994.

2. Certification or Licensure Change. Upon a change in certification or licensure level of the facility, the base rate for any added level of care, for which no base rate exists, shall be the base rate from the next lower level of care.

3. Newly-Licensed Beds. A newly-licensed facility which is in its start-up period as of June or July 1994 shall have zero base rates. A facility with significant licensed bed increases which is in its start-up period as of June or July 1994 shall have as its base rates those rates effective at the end of the month prior to the licensure of the new beds.

   Such base rates shall be limited for the current rate calculation to a maximum which shall be the facility's average base expense as determined in Section 3.731. If the average base rate is limited by the maximum, base rates for each level of care shall be calculated by multiplying the unlimited base rates for each level of care by a ratio of the maximum divided by the unlimited average base rate.

4. Temporary Bed Reductions. If the June 30, 1994, base rates were retrospectively adjusted for temporary bed reductions due to renovation projects, such rates shall be the base rates for application of this section until completion of the renovation period. After completion of the renovation period, the base rates shall be those rates effective for date of service June 30, 1994, prior to the retrospective rate adjustment for recognition of the temporary bed reduction.

3.730 Projected Expense

The projected expense shall be the sum of the average expense per patient per day, which was used in the calculation of each allowance in Sections 3.100 through 3.400 and 3.600, after being adjusted to the payment year as follows:

1. Direct care inflation adjusted expense from Section 3.120 shall be inflated by 2.8%.
2. Support services expense from Section 3.220 shall be inflated by 2.8%.
3. Administrative and general services expense from Section 3.250 shall be inflated by 2.8%.
4. Fuel and utility expense from Section 3.310 shall be inflated by 2.8%.
5. The property tax expense from Section 3.400 shall be inflated by 2.8%.
6. Over-the-counter drug allowance from Section 3.600 shall be inflated by 2.8%.

3.740 Current Methods Rate

A facility's current Methods rate for each level of care shall be the sum of the payment allowances resulting from Sections 3.100 through 3.400 and 3.600. A weighted average current Methods rate shall be calculated

3.760 Hold-Harmless Rate

The facility's average hold-harmless rates shall be the base rates under Section 3.720.

3.770 Selection of Payment Rate

3.772 Hold-Harmless Rate

The hold-harmless rates under 3.760 shall be the facility's payment rates if both of the following conditions are met:

1. The average current Methods rate under 3.740 is less than the average base rate under 3.720.
2. The average current Methods rate is less than the projected expense under 3.732.

3.773 Current Methods Rate

The current Methods rates under Section 3.740 shall be the facility's payment rates if Section 3.772 does not apply.

3.774 Final

The property allowance determined under Section 3.500 and ancillary add-ons determined under Section 3.800 shall be added to the rates selected under Sections 3.772 or 3.773 above. The sum shall be the payment rates for the facility.

3.775 Special Allowances for Facilities Operated by Local Units of Government

A. Final Settlements for phase III interim payments in the SFY02 State plan (TN#01-006) will be reallocated but limited to the total phase III payments made under the SFY02 State plan and will be limited to the facilities that received phase III payments.

1. All facilities with a phase III payment in SFY02 will submit a cost report, on forms designated by the Department, for the period July 1, 2001 through June 30, 2002 by September 30, 2002.

2. The Department will determine the actual Medicaid deficit for July 1, 2001 through June 30, 2002.

3. The payments made under phase III in SFY02 will be reallocated. The basis for the reallocation will be the Medicaid deficit in A.2. above less the phase I direct care award from section 3.775 of the SFY02 state plan.

4. Increases or decreases as a result of the reallocation will be processed as adjustments to the SFY03 payments under section 3.775.

B. In recognition of the unique nature of nursing homes operated by local units of government, local government-operated homes are eligible to apply for supplemental funding. Government-operated facilities will be consistent with the definitions used in Section 2.710.

1. In order to participate in the supplement, the home must have on file with the Department and/or submit the following materials:

   a. A cost report as required in Section 1.170.

   b. A prospective supplemental award application form.

   c. A additional cost report for facilities in phase down under the criteria in section 5 below. The cost report will cover the period January 1, 2002 through September 30, 2002 and must be submitted to the Department by December 31, 2002.

2. Supplemental funds awarded to the home will be made in lump sum payment(s).

3. Total supplemental funding shall not exceed $77,100,000. The Department shall reduce the supplemental funding to the local units of government if it determines that the aggregate payments to nursing homes under these Methods would exceed the Medicare upper limit.

4. The following methodology will be used to distribute funds under this Section:

   a. Based upon the cost report and the rates established under the Methods, the Department will determine the following (Medicaid/Family Care-Medicaid) deficits for July 1, 2002 through June 30, 2003: The (Medicaid/Family Care-Medicaid) deficits will be determined by using both the Medicaid and the Family Care-Medicaid patient days.

      1) The Projected Direct Care Operating Deficit (DCOD)

      2) The Projected Overall Operating Deficit (OAOD)

      3) The Eligible Direct Care Deficit (EDCD) (Equal to the lesser of the DCOD or the OAOD).

      4) The projected non-direct care deficit (Equal to the OAOD less the EDCD).

   The Department will issue a report to each applicant facility detailing its DCOD and OAOD.

   b. The Department will distribute, $77,100,000 or the aggregate OAOD, whichever is less, in supplemental funding as follows":

      1) The OAOD for facilities in phase down per section 5 below. The cost report in B.1.c. will be used to determine the OAOD for these facilities.

         a) In determining allowable costs for the special cost report in B.1.c, nd prior to making final supplemental payments under this section, the Department will adjust for the-following nonrecurring costs: accrued wages and fringe benefits, projected patient relocation expenses, and pension and related interest payments to reduce unfunded liability obligations. These adjustments are required to:

            1) Remove one-time, non-relocation expenses that were included in the special cost report but incurred prior to the reimbursement period (1/1/2002 to 6/30/2002).
            2) Not annualize one-time expenses that were included in the special cost report and incurred during the reimbursement period (7/1/2002 to 9/30/2002).
            3) Include one-time expenses that were incurred after the special cost report period but prior to the end of the reimbursement period (10/1/2002 to 6/30/2003)."

         b) The allowable cost per patient day less the average Medicaid rate payments per day shall be considered the OAOD per day.
         c) The OAOD per day times the (Medicaid/Family Care-Medicaid) patient days from the cost report (annualized to 365 days) shall constitute the phase down payment

      2) The EDCD for facilities that did not receive an award in step 1. If there are insufficient funds to reimburse facilities EDCD, then the distribution of funds shall be made as follows:

a) The sum of the EDCD shall be divided by the beds for rate setting for the facilities with EDCD to determine the loss per bed.

b) The loss per bed will be reduced by 50%.

c) Each facility shall receive a payment equal to their beds for rate setting multiplied by the per bed rate calculated in steps one and two, not to exceed their EDCD.

d) If there are insufficient funds the 50% adjustment in step 2 will be reduced so the calculation in step 3 will equal the remaining funds.

e) Any remaining funds after step 3, should be distributed to facilities that still have direct care deficits in proportion to their remaining EDCD.

3) The non-direct care deficits for facilities that did not receive an award in step 1.

If the remaining funds are insufficient to cover all non-direct care deficits the remaining funds shall be divided among facilities in proportion to the amount of their respective non-direct care deficits.

4) The awards for each nursing home will be adjusted proportionately base on the Medicaid patient days and the Family Care-Medicaid patient days. The nursing home will receive payments based on the Medicaid patient days.

5. Eligibility for Phasedown Payments for Significant Decreases in Licensed Beds.

a. Local government-operated nursing homes are eligible for the supplement if they meet the following:

1) The county board or governing body of the local unit of government passed a resolution by June 30, 2001 to downsize the facility during the current payment period;

2) The reduction began on or before June 30, 2001;

3) The downsizing will result in a decrease in licensed bed capacity that is the lesser of: (1) a reduction that is greater than or equal to 25.0% of the previously unrestricted use beds or (2) 50 beds; and

4) Were in a phasedown on June 30, 2002.

b. Nursing homes eligible for payment under this section may not receive payment adjustments under section 4.500 for the same period.

c. Phase-Down Period The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period, which may be modified as needed during the phase-down.

C. Based upon a transfer agreement and the subsequent transfer of funds, the Department will make exceptional payments in addition to the amount under Section B.3., to government operated nursing homes as provided subsections 1 and 2.

1. To qualify for exceptional payments under the Medicaid program, a nursing home must meet the following criteria:

a. Meet the participation requirements set forth in Section 5; and

b. Be located in a county where and based on the home's fiscal year 2000-2001 Medicaid cost report, either:

1) provide at least 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $3 million; or projected Medicaid deficits, for the 2001/02 rate year, for all nursing homes owned and operated by the county totaled at least $4,500,000.

2) provide between 80,000 and 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $4.0 million. Adjusted Medicaid patient days from the 1999 cost reports for all facilities owned and operated by the county totaled at least 80,000.

c. The county board passed a resolution by June 30, 2001 to downsize the facility during the current payment period.

2. Local government-operated homes qualifying for exceptional payments under subsection 1 will receive an exceptional nursing home payment determined as follows:

a. For each State Fiscal Year, the Department will calculate the maximum additional payments it can make in conformance with 42 CFR 447.272; The minimum payment will be the upper limit in section 3.780 less projected Medicaid payments for comparable services. The projected Medicaid services will include the final payment rate in 3.772, the appeals board payments in 1.400, SNF ancillary services, Medicaid payments for pharmacy, lab & radiology, physical therapy, occupational therapy and speech therapy, special payments in 3.77 B., and special payments under section 4.000 of the plan.

b. The Department will determine the total additional payments to be made to qualifying nursing homes in a manner not to exceed the maximum amount determined in 2.a.;

c. The Department will determine the total Medicaid costs for each qualifying nursing home using the most recent cost reports on file with the Department;

d. The Department will divide the Medicaid costs for each qualifying nursing home by the total Medicaid costs for all qualifying nursing homes to determine each qualifying nursing home's payment factor; and

e. The Department will determine each qualifying nursing home's exceptional payment amount by multiplying the nursing home's payment factor calculated in 2.d. by the total additional payment amount determined in 2.b. to establish the exceptional payment for the nursing home.

f. The payment will be made annually.

3.780 Calculation of Medicare Upper Limit

The upper limit is applied in aggregate to each of six categories of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs/MR):

- NFs owned or operated by the State
- Non-State government-owned NFs
- Privately-owned NFs
- ICFs/MR owned or operated by the State
- Non-State government-owned ICFs/MR
- Privately-owned ICFs/MR

Medicaid payments to any category may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the facilities under Medicare payment principles. This general rule was applied as follows to each category.

- NFs: Medicare pays for skilled nursing facility care under a prospective payment system (SNF PPS) with daily rates published in the Federal Register at the beginning of each Federal fiscal year. These rates vary by facility location, by resident resource utilization group (RUG) classification and cover a specified set of covered Medicare services. The estimated amounts Medicare would pay for Medicaid services within each of the three NF categories are the aggregate payments that would be applicable to Medicaid residents according to their RUG classification under the SNF PPS.

- Since the SNF PPS system does not apply to ICFs/MR and the RUG classification system is not applied to ICF/MR residents, we continue to use three component upper limits for ICF/MR payments consistent with the intent of the upper limit regulations. Specifically, each of the three ICF/MR upper limits is taken to be the lesser of the aggregate amount of a) allowable costs, b) a routine service limit (RSL), and c) what would be payable using private-pay rates. The RSL is taken to be 112% of the median allowable cost for facilities in the same category.

Note also that the calculations of SFY 2003 Medicaid payments and upper limit values are based upon information that is available at the time the State Plan is filed with CMS. That is, the calculations are prospective in nature and actual Medicaid payments may vary from estimates due to differences in actual and expected 2001 cost report data (used to set the Medicaid rates) and SFY 2003 Medicaid patient days, among other items.

3.790 Purchased Relocation Services

Payment for relocation services may be paid as a lump sum, in addition to the daily payment rate, if all of the requirements listed below are met.

- The relocation plan(s) must be ordered by the Department
- The Department must approve the contractor performing the services.
- Only services such as assessment of the resident for alternate placements, preparing contracts for community-based services and developing the community-based care provided by and paid to an outside contractor are allowable. All staff costs are allowable in the Methods and are not eligible for the lump sum payment.
- The amount allowed must meet all Departmental contracting limits.

The Department will pay the Medicaid portion of the allowed Purchased Relocation Services. The percentage of residents that were Medicaid during the month prior to the relocation order will be used as the Medicaid portion. The Department may, at their sole discretion, pay 100% of the allowed Purchased Relocation Services if the request is made prior to contract signature and it is shown to be in the Departments best interest.

Example: The Nursing Home receives a relocation order from the Department on July 15. They hire Apex Relocation Services to relocate all 100 residents in the next 60 days for a cost of $15,000. The Department approves the contract with Apex and the contract amount of $15,000. During June, 75 of the 100 residents were paid through Medicaid. Therefore, $11,250 ($15,000* 75%) will be paid to The Nursing Home as a lump sum.

If this section does not apply, the relocation services will be included in the cost report and paid accordingly.

3.800 ANCILLARY BILLABLE ITEMS

3.801 Medical Transportation

Medical transportation may be separately billed by a nursing home provider as an ancillary. Billings may not exceed the nursing home's actual cost. A per patient day ancillary add-on to the payment rate may be allowed for the cost of transportation services, but not to exceed the amount which would have been separately billable by the facility. The Department shall retain its authority under s. 49.45(10), Wis. Stats., to modify this paragraph.

3.802 Oxygen

A nursing home may bill for oxygen in cubic feet, pounds, tanks or for the daily rental of oxygen concentrators. The nursing home must use the claim form approved by the Department for oxygen billing. The nursing home will be subject to maximum fees for these services. Prior authorization is required for more than 30 days' rental of an oxygen concentrator for a resident.

3.810 Add-Ons for Separately Billable Items

3.811 Ancillary Add-Ons

A per patient day add-on to the daily rate may be allowed for the cost incurred by the facility for specifically identified covered services and materials which could be billed separately to the Medicaid Program by an independent provider of service. These services and materials must be available to all Medicaid recipients of the facility. If some portion of the services and materials must be supplied by an outside provider, the facility is responsible for payment to the outside provider.

The maximum amount allowed a facility for an add-on shall be the estimated maximum reimbursement available to independent providers for such services and materials when billing the Medicaid Program separately. The Department may exclude all costs in excess of this maximum. Such costs shall be from the reporting period(s) specified by the Department. If an add-on is approved, then neither the facility nor independent provider or providers of service may bill or charge the Medicaid Program separately for the material or services which are covered by the add-on. If a special need arises, i.e., something not covered by the add-on for any resident, the facility must receive approval from the Department in advance, in order for an independent provider to be reimbursed for the service or material.

NOTE: Each facility with an ancillary must demonstrate that the add-on to the daily rate is equal to or less costly than if the service was reimbursed to an independent provider through separate billings. If a facility requests a new ancillary add-on, the facility must demonstrate to the Department that the add-on meets the requirement of this section before the add-on is approved. The method of reporting the estimated expenditure shall be specified by the Department.

3.812 Adjustment for Changes in Practice

It is possible that a facility may wish to begin or resume billing some services or materials separately, after having had ancillary add-ons previously incorporated into its daily rate. If that occurs, the Department may make a reasonable and appropriate off-setting reduction to the facility's previous or current payment rate to exclude an ancillary add-on for the service. THE FACILITY SHALL NOTIFY THE DEPARTMENT OF THE CHANGE 30 DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE.

3.900 REIMBURSEMENT OF STATE-OPERATED FACILITIES

3.910 General

The state-owned nursing facilities and ICF-MRs serve a unique population of residents in Wisconsin. Determination of payments will be guided by the provisions below and by the appropriate sections of state statute.

3.920 Direct Care, Support Services Administrative and General, Fuel and Utilities and Property Tax

The maximums and limitations in Sections 3.100 through Section 3.400 shall not be applied in determining payments to state-operated facilities. The amount of the final payment shall be based upon the actual and allowable costs in the cost reporting period. Interim rates and cost reconciliation procedures are described in Sections 3.960 and 3.980.

3.930 Ancillary Add-Ons
Actual and allowable ancillary expenses as described under Section 3.800 for a time period established by the Department shall be used to calculate the final ancillary add-on costs. Interim add-ons will be set as described in Section 3.960. Underpayments or overpayments for ancillary add-on costs shall be included in the reconciliation described in Section 3.980. The maximums and limitations in Section 3.610 shall not be applied in determining payments to these facilities.

3.940 Capital Costs
Actual and allowable capital expenses for the cost reporting period shall be used to calculate the final property allowance. The property allowance shall be subject to reconciliation under Section 3.980.

3.950 Reporting Limitations
The facilities shall be subject to all cost reporting requirements, and payments shall be limited to allowable costs described in Section 1.200. The costs of teaching and vocational counseling services rendered residents under age 22 as part of an active treatment plan are only allowable in facilities licensed as ICF-MRs. The facilities will maintain adequate records so that audits of costs may be conducted to determine payable costs.

3.960 Interim Payment Rates
Interim payment rates may be established and will be subject to the cost reconciliation under Section 3.980.

3.970 Reimbursement Limitation
Total reimbursement for the payment rate year for state-owned facilities for patient care shall not exceed the Medicare upper limit.

3.980 Cost Reconciliation
A cost reconciliation will be conducted at the end of each state-owned facility's fiscal year. If payment at the interim rates does not exceed the Medicare upper limit, then the facility will be reimbursed the difference. If the payments at the interim rates are above the Medicare upper limit, then the difference will be recovered. However, in no case shall the total Medicaid payment exceed the limitations described in Section 3.970.